MATTERS ARISING

The British Journal of Venereal Disease and Genitourinary Medicine in the first 70 years

In a recent article published in *Genitourin Med* by Dr Oriel[1] titled *The British Journal of Venereal Disease and Genitourinary Medicine: the first 70 years*, the author notes on page 238 that there are now "three journals in the English language devoted to venereology". We would like to point out that, in fact, there are more than three journals in English devoted to venereology, and this, for example, includes *Venereology*.

Venereology (its name is derived from Venus, the goddess of love) is concerned with the interdisciplinary study of sexuality and health, including sexually transmissible diseases, and is listed in a number of medical and sociobehavioural indexes. The journal was established in Australia in 1987 and has a readership and authorship focus based in Australasia, Asia and the Pacific.

With the movement towards globalisation it is increasingly important for those who work within the North American and European axis not to overlook the literature published elsewhere, such as Australia and the Asia-Pacific region. We would like to congratulate *Genitourinary Medicine* on the fine work undertaken in the last 70 years in this field. We look forward to further establishing and extending ongoing collaborations with our colleagues around the globe.

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1 Oriel JD. The *British Journal of Venereal Disease and Genitourinary Medicine*: the first 70 years. *Genitourin Med* 1994;70:235–9.

The value of colposcopy in genitourinary medicine

I was pleased to see the reply by Moss[1] to my comments[2] on Moss *et al's* paper.[3] In his reply, Moss states that "there are at least two valid reasons for considering carefully prepared prospective primary colposcopy studies . . ." indeed I would hope that my own study[4] would be regarded as such a study. It failed to show any value of primary colposcopy in a genitourinary medicine setting. The *alleged* valid reasons given are of: a correlation between some smear abnormalities and of concomitant lower genital tract infection (this might be used to justify STD screening in some groups of colposcopy clinic attenders but hardly the reverse!); and "to be aware of discrepancies between cytology and histology" (such a truth can hardly be more widely accepted and proven by countless studies and anecdotes)

Moss then goes on to criticise my comments concerning my own paper[4] and that of Giles and colleagues.[5] His comments suggest a lack of familiarity with at least one of these papers. Rather than "arbitrarily combining two studies with different methodologies", I was seeking to highlight similarities between the results of two studies with similar methodology, but in two different populations. My paper included in the discussion a further analysis of some of Giles and colleagues' data—the accuracy of that analysis was confirmed by the senior author of Giles' paper (Walker, PG personal communication). As is well known, Giles' paper showed about three times as many cases of colposcopically detected cervical disease as did cytology in the same women (the excess being largely minor or small area disease). My further analysis of those data—using the ages of the women, as published in the original paper—showed that in young women (aged under 30 years) the discrepancy between cytology and colposcopy was even higher, again due to minor disease. This was such that about a third of all younger women screened by primary colposcopy (in a general practice setting) had cervical epithelial disease. This proportion being almost identical to that found in my study of women with warts and other genitourinary medicine clinic attenders. In short if you use primary colposcopy you will find a vast number of minor cervical epithelial "abnormalities", the clinical relevance of which is extremely dubious.

Moss goes on to refer to a "consensus" view on colposcopy in genitourinary medicine practice,[6] this being the report of a workshop chaired by Moss. This report fails to support a role for primary colposcopy in such clinics and concludes "The concept of identifying a very high risk group within this genitourinary medicine population is attractive, but no risk factors are sufficiently strong to indicate that targeting resources to a particular group will improve the success of the National Cervical Screening Programme."

Moss and colleagues have advanced no evidence that primary colposcopy in genitourinary medicine clinics has anything to offer over routine, established, cytological screening. Until they do I would urge genitourinary physicians to refrain from primary colposcopy, except perhaps in the context of *further* "carefully prepared prospective research".

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1 Moss TR. The value of primary colposcopy in genitourinary medicine. *Genitourin Med* 1994;70:426.
2 Griffiths M. The value of primary colposcopy in genitourinary medicine. *Genitourin Med* 1994;70:425.
3 Moss TR, Hawkswell J, Fogarty B, Dadswell C. The value of primary colposcopy in genitourinary medicine—a six year review. *Genitourin Med* 1994;70:191–5.
4 Griffiths M, Sanderson D, Penna LK. Cervical epithelial abnormalities among women with warts—no more common than among controls. *Int J Gynecol Cancer* 1992;2:49–51.
5 Giles JA, Hudson E, Crow J, *et al.* Colposcopic assessment of the accuracy of cervical cytology screening. *BMJ* 1988;296:1099–102.
6 The role of genitourinary medicine cytology and colposcopy in cervical screening: Does the GU female population merit a different cytology/colposcopy strategy? *NHS Cervical Screening Programme*, National Coordinating Network, Oxford 1994.

Acute urinary retention preceding skin manifestations of genital herpes by 8 days

Cybulska and Barlow report a very interesting case of acute urinary retention preceding the clinical appearance of gential herpes by several days.[1] They rightly stated the need for urologists to be aware of the possibility of herpes in young adults presenting with acute retention. We made a similar plea in 1986 in our report of two cases of urinary retention associated with clinically occult ano-rectal herpes.[2] Patients with retention may present to family practitioners or accident and emergency departments and are then often referred to urology or surgical departments. Although there are reports in the urology literature of urinary retention secondary to genital herpes,[1] our clinical experiences suggest that the diagnosis may still be overlooked, particularly when lesions are not apparent at presentation. This may happen either because the lesions are in a hidden location (for example on the cevix or in the anal canal), or because of their small size or because of timing, that is, the presentation of the lesions is not concurrent with the complaint of retention. In Cybulska and Barlow's patient, retention preceded the lesions by eight days, whereas retention usually starts later in the course of the lesions or even sometimes after they have healed.

Interdisciplinary audit provides an important forum for discussion and we would therefore strongly recommend that acute retention in the young should be added to the list of mutually relevant topics for Urology/GU Medicine audit. In view of the rarity of such cases, this type of audit may be better approached at a regional level.

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1 Cybulska BA, Barlow D. Acute urinary retention preceding skin manifestation of genital herpes by 8 days. *Genitourin Med* 1994;70:362.
2 Atia W, Sonnex C. Retention of urine in occult ano-rectal herpes. *BMJ* 1986;292:239.

NOTICE